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APPENDIX C

REQUIRED RECIPIENT RECORD DOCUMENTATION

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APPENDIX C

REQUIRED RECIPIENT RECORD DOCUMENTATION

Examples of the following documentation required for client records are included in this appendix:

- Virginia Uniform Assessment Instrument (UAI);
- Medicaid-funded Long-Term Care Preadmission Screening Authorization (DMAS-96 revised 8/97);
- Individualized Service Plan; and
- Adult Care Residence Eligibility Communication Document.

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen: ____/____/____

Assessment: ____/____/____

Reassessment: ____/____/____

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ Client SSN: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: () _____ City/County Code: _____

Directions to House:

Pets?

Demographics

Birthdate: ____/____/____
(Month) (Day) (Year)

Age: _____

Sex: ____ Male 0 ____ Female 1

Marital Status: ____ Married 0 ____ Widowed 1 ____ Separated 2 ____ Divorced 3 ____ Single 4 ____ Unknown 9

Race:

- ____ White 0
- ____ Black/African American 1
- ____ American Indian 2
- ____ Oriental/Asian 3
- ____ Alaskan Native 4
- ____ Unknown 9

Education:

- ____ Less than High School 0
- ____ Some High School 1
- ____ High School Graduate 2
- ____ Some College 3
- ____ College Graduate 4
- ____ Unknown 9

Communication of Needs:

- ____ Verbally, English 0
- ____ Verbally, Other Language 1
- Specify: _____
- ____ Sign Language/Gestures/Device 2
- ____ Does Not Communicate 3
- Hearing Impaired? _____

Ethnic Origin: _____ Specify: _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ Relationship: _____

Address: _____ Phone: (H) _____ (W) _____

Name: _____ Relationship: _____

Address: _____ Phone: (H) _____ (W) _____

Name of Primary Physician: _____ Phone: _____

Address: _____

Initial Contact

Who called: _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

Client SSN: - -

Do you currently use any of the following types of services?

Provider/Frequency:

-
- This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slightly textured appearance and is set against a dark background.

Where are you on this scale for annual (monthly) family income before taxes?

- Optional: Total monthly family income: _____

No 0 Yes 1 Optional: Amount

- Does anyone cash your check, pay your bills or manage your business?

_____ Legal Guardian, _____
 _____ Power of Attorney, _____
 _____ Representative Payee, _____
 _____ Other, _____

No 0 Yes 1

- What types of health insurance do you have?

Medicare, # _____

Medicaid, # _____

Pending: ☐ No 0 ☐ Yes 1

QMB/SLMB: ☐ No 0 ☐ Yes 1

All Other Public/Private: _____

CLIENT NAME:

Client SSN: - -

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household	
___ House: Own 0					
___ House: Rent 1					
___ House: Other 2					
___ Apartment 3					
___ Rented Room 4					
	Name of Provider (Place)			Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50					
___ Adult Foster 60					
___ Nursing Facility 70					
___ Mental Health/ ___ Retardation Facility 80					
___ Other 90					

Where you usually live, are there any problems?

No 0	Yes 1	Check All Problems That Apply	Describe Problems:
___	___	Barriers to Access	
___	___	Electrical Hazards	
___	___	Fire Hazards/No Smoke Alarm	
___	___	Insufficient Heat/Air Conditioning	
___	___	Insufficient Hot Water/Water	
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)	
___	___	Lack of/Defective Stove, Refrigerator, Freezer	
___	___	Lack of/Defective Washer/Dryer	
___	___	Lack of/Poor Bathing Facilities	
___	___	Structural Problems	
___	___	Telephone Not Accessible	
___	___	Unsafe Neighborhood	
___	___	Unsafe/Poor Lighting	
___	___	Unsanitary Conditions	
___	___	Other: _____	

CLIENT NAME:

Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?	
	No 00	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

MH Only 10 Mechanical Help	HH Only 2 Human Help	MH & HH 3	Performed by Others 40	Is Not Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2
			Spoon Fed 1	Syringe/Tube Fed 2
			Fed by IV 3	

Continence	Needs Help?	
	No 00	Yes
Bowel		
Bladder		

Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6

Comments:

Ambulation	Needs Help?	
	No 00	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

MH Only 10 Mechanical Help	HH Only 2 Human Help	MH & HH 3	Performed by Others 40	Is Not Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2
			Confined Moves About	Confined Does Not Move About

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

___ No, Continue with Section 0

___ Yes, Service Referrals 1

___ Yes, No Service Referrals 2

Screener:

Agency:

CLIENT NAME:

Client SSN:

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a ... for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as ... (Who has it ... Where is it ...)?

No 0 Yes 1

Location

Living Will, _____
 Durable Power of Attorney for Health Care, _____
 Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as ... (Refer to the list of diagnoses)?

Current Diagnoses

Date of Onset

_____	_____
_____	_____
_____	_____
_____	_____

Enter Codes for 3 Major, Active Diagnoses: _____ None 00 _____ DX1 _____ DX2 _____ DX3

Current Medications
(Include Over-the-Counter)

Dose, Frequency, Route

Reason(s) Prescribed

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
0. _____	_____	_____

total No. of Medications: _____ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: _____

Do you have any problems with medicine(s) ... ?

How do you take your medicine(s)?

No 0 Yes 1

Adverse reactions/allergies _____
 Cost of medication _____
 Getting to the pharmacy _____
 Taking them as instructed/prescribed _____
 Understanding directions/schedule _____

Without assistance 0 _____
 Administered/monitored by lay person 1 _____
 Administered/monitored by professional nursing staff 2 _____
 Describe help: _____
 Name of helper: _____

Diagnoses:

- Alcoholism/Substance Abuse (01)
- Blood-Related Problems (02)
- Cancer (03)
- Cardiovascular Problems
 - Circulation (04)
 - Heart Trouble (05)
 - High Blood Pressure (06)
 - Other Cardiovascular Problems (07)
- Dementia
 - Alzheimer's (08)
 - Non-Alzheimer's (09)
- Developmental Disabilities
 - Mental Retardation (10)
- Related Conditions
 - Autism (11)
 - Cerebral Palsy (12)
 - Epilepsy (13)
 - Friedreich's Ataxia (14)
 - Multiple Sclerosis (15)
 - Muscular Dystrophy (16)
 - Spina Bifida (17)
- Digestive/Liver/Gall Bladder (18)
- Endocrine (Gland) Problems
 - Diabetes (19)
 - Other Endocrine Problems (20)
- Eye Disorders (21)
- Immune System Disorders (22)
- Muscular/Skeletal
 - Arthritis/Rheumatoid Arthritis (23)
 - Osteoporosis (24)
 - Other Muscular/Skeletal Problems (25)
- Neurological Problems
 - Brain Trauma/Injury (26)
 - Spinal Cord Injury (27)
 - Stroke (28)
 - Other Neurological Problems (29)
- Psychiatric Problems
 - Anxiety Disorders (30)
 - Bipolar (31)
 - Major Depression (32)
 - Personality Disorder (33)
 - Schizophrenia (34)
 - Other Psychiatric Problems (35)
- Respiratory Problems
 - Black Lung (36)
 - COPD (37)
 - Pneumonia (38)
 - Other Respiratory Problems (39)
- Urinary/Reproductive Problems
 - Renal Failure (40)
 - Other Urinary/Reproductive Problems (41)
- All Other Problems (42)

CLIENT NAME:

Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment		Complete Loss 3	Date of Last Exam
		Record Date of Onset/Type of Impairment			
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

- ☐ Within normal limits or instability corrected 0
☐ Limited motion 1
☐ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
<input type="checkbox"/> None 000 <input type="checkbox"/> Hip Fracture 1 <input type="checkbox"/> Other Broken Bone(s) 2 <input type="checkbox"/> Dislocation(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Fracture/Dislocation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Finger(s)/Toe(s) 1 <input type="checkbox"/> Arm(s) 2 <input type="checkbox"/> Leg(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Amputation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Total 2 Describe: _____ Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Onset of Paralysis? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2

Nutrition

Height: _____ (inches) Weight: _____ (lbs.) Recent Weight Gain/Loss: ☐ No 0 ☐ Yes 1

Describe: _____

Are you on any special diet(s) for medical reasons?	Do you have any problems that make it hard to eat?
<input type="checkbox"/> None 0 <input type="checkbox"/> Low Fat/Cholesterol 1 <input type="checkbox"/> No/Low Salt 2 <input type="checkbox"/> No/Low Sugar 3 <input type="checkbox"/> Combination/Other 4 Do you take dietary supplements? <input type="checkbox"/> None 0 <input type="checkbox"/> Occasionally 1 <input type="checkbox"/> Daily, Not Primary Source 2 <input type="checkbox"/> Daily, Primary Source 3 <input type="checkbox"/> Daily, Sole Source 4	No 0 Yes 1 <input type="checkbox"/> <input type="checkbox"/> Food Allergies <input type="checkbox"/> <input type="checkbox"/> Inadequate Food/Fluid Intake <input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting/Diarrhea <input type="checkbox"/> <input type="checkbox"/> Problems Eating Certain Foods <input type="checkbox"/> <input type="checkbox"/> Problems Following Special Diets <input type="checkbox"/> <input type="checkbox"/> Problems Swallowing <input type="checkbox"/> <input type="checkbox"/> Taste Problems <input type="checkbox"/> <input type="checkbox"/> Tooth or Mouth Problems <input type="checkbox"/> <input type="checkbox"/> Other: _____

CLIENT NAME:

Client SSN: - -

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as ... ?

No 0 Yes 1 Frequency

___ Occupational _____

___ Physical _____

___ Reality/Remotivation _____

___ Respiratory _____

___ Speech _____

___ Other _____

Do you have any pressure ulcers?

___ None 0 Location/Size

___ Stage I 1 _____

___ Stage II 2 _____

___ Stage III 3 _____

___ Stage IV 4 _____

Special Medical Procedures: Do you receive any special nursing care, such as ... ?

No 0 Yes 1 Site, Type, Frequency

___ Bowel/Bladder Training _____

___ Dialysis _____

___ Dressing/Wound Care _____

___ Eyecare _____

___ Glucose/Blood Sugar _____

___ Injections/IV Therapy _____

___ Oxygen _____

___ Radiation/Chemotherapy _____

___ Restraints (Physical/Chemical) _____

___ ROM Exercise _____

___ Trach Care/Suctioning _____

___ Ventilator _____

___ Other: _____

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

CLIENT NAME:

Client SSN: - -

4 PSYCHO - SOCIAL ASSESSMENT

Cognitive Function

Orientation (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)

Person: Please tell me your full name (so that I can make sure our record is correct).

Place: Where are we now (state, county, town, street/route number, street name/box number)?
Give the client 1 point for each correct response.

Time: Would you tell me the date today (year, season, date, day, month)?

- ☐ Oriented 0
☐ Disoriented - Some spheres, some of the time 1
☐ Disoriented - Some spheres, all the time 2
☐ Disoriented - All spheres, some of the time 3
☐ Disoriented - All spheres, all of the time 4
☐ Comatose 5

Spheres affected: _____

Optional: MMSE Score

(5)

(5)

Recall/Memory/Judgement

Recall: I am going to say three words, and I want you to repeat them after I am done (House, Bus, Dog). ☛ Ask the client to repeat them. Give the client 1 point for each correct response on the first trial. ☛ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/Concentration: Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).

Short-Term: ☛ Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgement: If you needed help at night, what would you do?

No 0 Yes 1

- ☐ ☐ Short -Term Memory Loss?
☐ ☐ Long-Term Memory Loss?
☐ ☐ Judgement Problem?

(3)

(5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?

- ☐ Appropriate 0
☐ Wandering/Passive - Less than weekly 1
☐ Wandering/Passive - Weekly or more 2
☐ Abusive/Aggressive/Disruptive - Less than weekly 3
☐ Abusive/Aggressive/Disruptive - Weekly or more 4
☐ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as ... ?

- | | | |
|---|---|---|
| No 0 Yes 1 | No 0 Yes 1 | No 0 Yes 1 |
| <input type="checkbox"/> <input type="checkbox"/> Change in work/employment | <input type="checkbox"/> <input type="checkbox"/> Financial problems | <input type="checkbox"/> <input type="checkbox"/> Victim of a crime |
| <input type="checkbox"/> <input type="checkbox"/> Death of someone close | <input type="checkbox"/> <input type="checkbox"/> Major illness - family/friend | <input type="checkbox"/> <input type="checkbox"/> Failing health |
| <input type="checkbox"/> <input type="checkbox"/> Family conflict | <input type="checkbox"/> <input type="checkbox"/> Recent move/relocation | <input type="checkbox"/> <input type="checkbox"/> Other: _____ |

CLIENT NAME:

Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1

Describe

- ☐ Solitary Activities, _____
☐ With Friends/Family, _____
☐ With Groups/Clubs, _____
☐ Religious Activities, _____

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children

Other Family

Friends/Neighbors

☐ No Children 0

☐ No Other Family 0

☐ No Friends/Neighbors 0

☐ Daily 1

☐ Daily 1

☐ Daily 1

☐ Weekly 2

☐ Weekly 2

☐ Weekly 2

☐ Monthly 3

☐ Monthly 3

☐ Monthly 3

☐ Less than Monthly 4

☐ Less than Monthly 4

☐ Less than Monthly 4

☐ Never 5

☐ Never 5

☐ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

☐ No 0 ☐ Yes 1

CLIENT NAME:

Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2

How much: _____

How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2

How much: _____

How often: _____

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

<p>Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?</p> <p>___ No 0 ___ Yes 1</p> <p>Describe concerns: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Do (did) you ever use alcohol/other mood-altering substances with...</p> <p>No 0 Yes 1</p> <p>___ ___ Prescription drugs?</p> <p>___ ___ OTC medicine?</p> <p>___ ___ Other substances?</p> <p>Describe what and how often:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Do (did) you ever use alcohol/other mood-altering substances to help you...</p> <p>No 0 Yes 1</p> <p>___ ___ Sleep?</p> <p>___ ___ Relax?</p> <p>___ ___ Get more energy?</p> <p>___ ___ Relieve worries?</p> <p>___ ___ Relieve physical pain?</p> <p>Describe what and how often:</p> <p>_____</p> <p>_____</p>
---	---	--

Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2

How much: _____

How often: _____

Is there anything we have not talked about that you would like to discuss?

CLIENT NAME:

Client SSN:



ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.

Caregiver Assessment

Does the client have an informal caregiver?

☐ No 0 (Skip to Section on Preferences) ☐ Yes 1

Where does the caregiver live?

- ☐ With client 0
☐ Separate residence, close proximity 1
☐ Separate residence, over 1 hour away 2

Is the caregiver's help ...

- ☐ Adequate to meet the client's needs? 0
☐ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

- ☐ Not at all 0
☐ Somewhat 1
☐ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

CLIENT NAME:

Client SSN:

Client Case Summary

Unmet Needs

No 0 Yes 1 (Check All That Apply)

___ ___ Finances
___ ___ Home/Physical Environment
___ ___ ADLS
___ ___ IADLS

No 0 Yes 1 (Check All That Apply)

___ ___ Assistive Devices/Medical Equipment
___ ___ Medical Care/Health
___ ___ Nutrition
___ ___ Cognitive/Emotional
___ ___ Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

Please provide the appropriate answer by either filling in the space or putting the correct code in the box provided.

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ____/____/____

Social Security _____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐

1 = Yes

2 = Not currently Medicaid eligible, anticipated within 180 days of nursing home admission **OR** within 45 days of application or when personal care begins.

3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing home admission

If no, has Individual formally applied for Medicaid? ☐

0 = No 1 = Yes

Is Individual currently auxiliary grant eligible? ☐

0 = No

1 = Yes, or has applied for auxiliary grant

2 = No, but is eligible for General Relief

Dept of Social Services:

(Eligibility Responsibility) _____

(Services Responsibility) _____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ACR screeners)

MEDICAID AUTHORIZATION

Level of Care

1 = Nursing Facility Services ☐

2 = PACE/LTC PHP

3 = AIDS/HIV Waiver Services

4 = Elderly & Disabled Waiver - Personal Care

5 = Elderly & Disabled Waiver - Adult Day Health Care

6 = Elderly & Disabled Waiver - ADHC and Personal Care

7 = Elderly & Disabled Waiver - Respite

10 = Consumer-Directed Personal Attendant Services

11 = ACR Residential Living

12 = ACR Regular Assisted Living

NO MEDICAID SERVICES AUTHORIZED

8 = Other Services Recommended

9 = Active Treatment for MI/MR Condition

0 = No other services recommended

Targeted Case Management for ACR

0 = No 1 = Yes ☐

Assessment Completed

1 = Full Assessment

2 = Short Assessment ☐

ACR provider name: _____

ACR provider number: _____

ACR admit date: _____

SERVICE AVAILABILITY

1 = Client on waiting list for service authorized ☐

2 = Desired service provider not available

3 = Service provider available, care to start immediately

Is this an ACR Reassessment?

0 = No 1 = Yes ☐

Short (Z8577) ☐

Long (Z8578) ☐

LENGTH OF STAY (If approved for Nursing Home)

1 = Temporary (less than 3 months) ☐

2 = Temporary..(less than 6 months)

3 = Continuing (more than 6 months)

8 = Not Applicable

LEVEL I/ACR SCREENING IDENTIFICATION

Name of Level I/ACR screener agency and provider number:

1. _____

--	--	--	--	--	--	--

2. _____

--	--	--	--	--	--	--

LEVEL II ASSESSMENT DETERMINATION

Name of Level II Screener and ID number:

1. _____

--	--	--	--	--	--	--

0 = Not referred for Level II assessment ☐

1 = Referred, Active Treatment needed

2 = Referred, Active Treatment not needed

3 = Referred, Active Treatment needed but individual chooses nursing home

Did the individual expire after the PAS/ACR Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

Level I/ACR Screener

Title

Date

Level I/ACR Screener

Title

Date

Level I Physician

Date

Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96)*

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.

Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.

Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the three-character code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

NFS = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.

EDW = **ELDERLY AND DISABLED WAIVER** authorize only if Individual meets NF or pre-NF criteria and requires a community-based service to prevent institutionalization. To authorize PERSONAL CARE, ADULT DAY HEALTH CARE or RESPITE CARE the servicing provider must also fill out a *Virginia Prior Review and Authorization Request* (DMAS-351) and submit it to the appropriate DMAS agency.

EDL = **LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.

AID = **AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements). To authorize Individual services, the servicing provider(s) must also fill out a *Virginia Prior Review and Authorization Request* (DMAS-351) and submit it to the appropriate DMAS agency.

ARC = **ACR RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.

ARR = **ACR REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.

If ARR is authorized, enter, if known, in item 29, the provider number of the ACR that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ACR.

PAC = **PACE** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization. Authorize only after the PACE program is in effect.

NON = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

OSR = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

12. (continued)

ATM = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.

13. Targeted Case Management for ACR *If ARC, ARR or ARI is authorized*, you must indicate whether Targeted Case Management for ACR (quarterly visits) are also being authorized. The Individual must require coordination of multiple services and the ACR or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.
14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
15. ACR Reassessment: If this is an ACR Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.
16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.
17. Level I/ACR Screening Identification Enter the name of the Level I screening & agency or facility (for example, Hospital, local DSS, local Health, Area Agency
18. on Aging, CSB, State MH/MR facility, CIL) and below it, in the 11 boxes provided, that entity's 8-digit provider ID and 3-digit location code.

For Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*
19. If the screening is a Nursing Home Pre-Admission Screening completed in the & locality, there should be two Level I screeners, both the local DSS and local
20. Health departments. Otherwise, there will only be one Level I screener identification entered.
Do NOT fill in Lines 16 and 17 or lines 18 and 19 if lines 20 and 21 are filled in. Submit a separate DMAS-96 form.
21. Level II Assessment Determination If a Level II assessment was performed (MI, & MR or Dual), enter the name of the assessor on line 20 and the provider number
22. on line 21. *Do NOT fill in line 20 and 21 if lines 16 and 17 are also filled in.* Submit a separate DMAS-96 form.
23. Enter the appropriate code in the box.
24. When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.
25. The Level I/ACR Screener must sign and date the form. **Required.**
26. The Level I/ACR Screener must sign and date the form. **Required for all services except ACR placement.**
27. The Level I physician must sign and date the form. **Required for all services except ACR placement.**
28. Enter the date the Individual entered an ACR. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter the date Medicaid Care of the Individual began in this space and place a copy of the form ON TOP of their admission packet.
29. Enter the name of the ACR in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their name in this space and place a copy of the form ON TOP of their admission packet.
30. Enter the provider number of the ACR in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their provider number in this space and place a copy of the form ON TOP of their admission packet.

INDIVIDUALIZED SERVICE PLAN

If applicable: Medicaid # _____
DMAS Provider ID# _____

Resident's Name: _____ Name of ACR: _____

See reverse side for signatures and additional information.

Description of needs is based upon the UAI, medical reports, and any additional assessments necessary to meet the care needs of the resident.

A. If the resident lives in a building housing 19 or fewer residents, does the resident need to have a staff member awake and on duty at night? ☐ Yes ☐ No

B. Description of Needs and Date Identified	Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes/Goals (Include Time Frames)

Resident's Name: _____

B. Description of Needs and Date Identified	Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes/Goals (Include Time Frames)

SIGNATURES:

Staff Person Who Completed Plan

Date Plan Completed

Resident

Date

Licensed Health Care Professional (630.J)
(For Assisted Living Residents)

Date

Other, if any, Involved in Development of Plan
(Specify Title/Relationship)

Date

PLAN REVIEW/MODIFICATIONS

NOTE: Changes in plan should be initiated by staff person making change, resident, and for assisted living residents, licensed health care professional (630.J).

Staff Person Designated to Review, Monitor, Ensure Implementation, and Make Appropriate Modifications to Plan: _____

Dates Implementation Monitored and Initials: _____

SIGNATURES:

Staff Person Who Completed Plan Review

Date

Staff Person Who Completed Plan Review

Date

**VIRGINIA DEPARTMENTS OF MEDICAL ASSISTANCE SERVICES/SOCIAL SERVICES
ADULT CARE RESIDENCE ELIGIBILITY COMMUNICATION DOCUMENT**

To/From: Dept. of Social Services Eligibility Worker in _____
(City/County Responsible for Auxiliary Grant)

Address: _____

To/From: _____ (ACR Assessor/Case Manager)

Address: _____

Assessor=s provider #: _____

RESIDENT: _____ **SSN:** _____

Medicaid #: _____

ACR: _____ **ACR Location:** _____

PURPOSE OF COMMUNICATION (check 1, 2, or 3):

____ **1. ANNUAL REASSESSMENT COMPLETED** Date of Reassessment: ____/____/____

a. ____ **Resident Continues to Meet Criteria for ACR Placement at the following level of care:**

____ Residential Living ____ Regular Assisted Living

b. ____ **Resident Does Not Meet Criteria for Residential or Assisted Living**

____ **2. RESIDENT NO LONGER RESIDES IN ACR ON RECORD.** Resident has been discharged to:

a. ____ **Another ACR.** Last Date of Service in the ACR on Record: ____/____/____

Name of New ACR: _____

Provider #: _____ Start of Care Date in New ACR: ____/____/____

Address of New ACR: _____

b. ____ **Home.** Last Date of Service in the ACR: ____/____/____

New Address: _____

c. ____ **Other** (please specify): _____

Last Date of Service in the ACR: ____/____/____

New Address: _____

____ **3. AUXILIARY GRANT ELIGIBILITY TERMINATED** Effective Date: ____/____/____

Reason: _____

(Name of Assessor/Case Manager Completing Form)		(Name of Eligibility Worker Completing Form)	
(Signature of Assessor/Case Manager Completing Form)		(Signature of Eligibility Worker Completing Form)	
(Date)	(Telephone No.)	(Date)	(Telephone No.)

ACR ELIGIBILITY COMMUNICATION DOCUMENT INSTRUCTIONS

WHEN TO USE THIS FORM

This form is a communication tool between the local department of social services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the adult care residence (ACR) resident, and DMAS. This form is completed:

1. By the assessor/case manager to the eligibility worker and to DMAS at the time of a 12-month reassessment (a finding that the resident continues to meet either residential or assisted living is required in order for the eligibility worker to redetermine eligibility for an Auxiliary Grant (AG) payment);
 2. By either the assessor/case manager or eligibility worker to the other and to DMAS whenever either becomes aware of a change in address; and
 3. By the eligibility worker to the ACR assessor/case manager and to DMAS whenever the AG is terminated.
-

TO/FROM SECTION

Both TO/FROM sections must be completed. Completely fill in the locality of the DSS eligibility worker with address and indicate whether document is to be sent to or from the eligibility worker by circling ATO≡ or AFROM.≡ In the second TO/FROM section, completely fill in the assessor or case manager=s name, address and provider number and indicate whether the document is to be sent to or from the assessor or case manager by circling ATO≡ or AFROM.≡

RESIDENT IDENTIFICATION SECTION

1. RESIDENT: Legibly print name of ACR resident who is being assessed, who has moved, or whose AG has been terminated.
 2. SSN: Write in the resident=s social security number. Record the resident=s Medicaid number.
 3. ACR: Legibly print the name of the ACR in which the resident resides.
 4. ACR location: List the city/town in which the ACR is located.
-

PURPOSE OF COMMUNICATION SECTION: Check either 1., 2., or 3.

If 1. is checked (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. (Resident continues to meet criteria for ACR placement at the following level of care) or b. (Resident does not meet criteria for residential or assisted living. If a. is checked, indicate which level of care the individual meets. When 1. is checked, the assessor sends a copy of the Uniform Assessment Instrument (UAI), the ACR Eligibility Communication Document (ECD), and the HCFA-1500 to DMAS. In addition, the assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ACR; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents.

NOTE: If a reassessment indicates a change in level of care, treat the assessment as a change in level of care. That is, send a copy of the UAI and the DMAS-96 to DMAS. In addition, send the eligibility worker a copy of the DMAS-96; send to the ACR copies of the UAI, DMAS-96, and decision letter; and send a decision letter to the individual being assessed. The assessor should keep a copy of each.

If 2. is checked (Resident no longer resides in ACR on record), indicate to where the resident moved (i.e., another ACR, home, or other). For each, indicate the last date of service in the ACR on record. Complete other information such as new address, etc., if known. When 2. is checked, the assessor/case manager or eligibility worker completing the ECD should send a copy to the other and a copy to DMAS and keep a copy for him- or herself.

If 3. is checked (Auxiliary Grant Eligibility Terminated), the eligibility worker indicates the effective date of termination and the reason. Then the eligibility worker sends a copy of the ECD to the assessor/case manager and to DMAS.

SIGNATURES SECTION

For each form completed, only one signature section will be completed. For example, if an assessor is completing the form for a reassessment, the left-hand side with assessor information will be completed. If the eligibility worker is completing the form for notification of AG eligibility termination, then the right-hand side is completed. Please completely fill in the applicable section with printed name of individual completing the form, signature, complete date with month/day/year, and telephone number with area code.

Please photocopy this form as needed; plain paper copies are acceptable.

FOR ADDITIONAL INFORMATION, PLEASE REFER TO THE *ASSESSMENT AND TARGETED CASE MANAGEMENT SERVICES IN ADULT CARE RESIDENCES: PROCEDURES FOR ASSESSORS AND CASE MANAGERS*. THIS MANUAL IS AVAILABLE FROM THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES, ADULT SERVICES PROGRAM, AT 804-692-1299.